PAYMENT AND REIMBURSEMENT POLICY

Title: PRP-04 Hospice Services

Category: Compliance

Medical Related Policy: BCP-22 Hospice Services

Effective Date: 01/01/2019

Physicians Health Plan
PHP Insurance Company
PHP Service Company

1.0 Guidelines:

This policy does not guarantee benefits. Benefits are determined and/or limited by an individual member Certificate of Coverage (COC). Reimbursement is not solely determined on this policy, Physicians Health Plan (PHP) reserves the right to apply coding edits to all medical claims through coding software and accuracy of claim submission according to industry billing standards. A prior authorization/approval does not exempt adherence to the following billing requirements.

2.0 Description:

Hospice services are considered by most as a philosophy or concept of care; it is not a specific place of care. A Hospice program is defined as a program of palliative and supportive care services providing physical, psychological, social, and spiritual care for dying persons, their families, and other loved ones. The treatment focus is palliative, not curative. Hospice care is not necessarily appropriate for everyone who has a terminal illness. In order to qualify for entry into a hospice program, the patient, the family and the attending physician must all accept the inevitability of the death process and relinquish all prospects of medical treatment that might aggressively prolong life, including artificial life support systems. Patients who may benefit from hospice services include those who are terminally ill and who require services for the palliation or management of the terminal illness and related conditions.

3.0 Policy:

Health Plan covers hospice care as a medical benefit when established criteria are met and supported by clinical documentation. Hospice services are provided in either an inpatient or outpatient setting and require approval prior to the health service being provided. Authorized services considered for reimbursement under the hospice benefit are included in the per diem rate are as follows:

- Skilled nursing care provided by or under the supervision of a registered nurse.
- Medical social services.
- Physician services.
- Counseling services, including:
  - Bereavement counseling.
  - Dietary counseling.
  - Spiritual counseling.
  - Other additional counseling.
- Physical, occupational, and speech/language therapy.
- Homemaker/home health aide services.
- Drugs/durable medical equipment/medical supplies.
- Short-term inpatient care other services covered by the Benefit plan that are not related to Hospice but would otherwise be covered, as long as such services do not exclude the member from electing hospice care.
- Volunteer services.

4.0 Coding and Billing:

Prior Approval Legend: Y = All lines of business; N = None required; 1 = HMO/POS; 2 = PPO; 3 = SHS 264; 4 = SHS 1269 non-union; 5 = LBWL; 6 = Dart; 7 = SHS 1269 union.

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Reference**
99378	Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	1, 2, 3, 4, 5, 6	Benefits and Coverage, Hospice Care, or Facility Services (Non Hospital)
G0156	Services of home health/health aide in home health or hospice settings, each 15 minutes	1, 2, 3, 4, 5, 6	Benefits and Coverage, Hospice Care, or Facility Services (Non Hospital)
S9126	Hospice care, in the home, per diem	1, 2, 3, 4, 5, 6	Benefits and Coverage, Hospice Care or Facility Services (Non Hospital)

NON-COVERED CODES		
Code	**Description**	**Benefit Plan Reference/Reason**
99377	Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	All Other Exclusions. Health services and medical supplies that do not meet the definition of a Covered Health Service.

FACILITY COVERED CODES			
Revenue Code	**Description**	**Prior Approval**	**Benefit Plan Reference**
0650	General	1, 2, 3, 4, 5, 6	Benefits and Coverage, Hospice Care, or Facility Services (Non Hospital)
0651	Routine home care	1, 2, 3, 4, 5, 6	Benefits and Coverage, Hospice Care, or Facility Services (Non Hospital)
0652	Continuous home care	1, 2, 3, 4, 5, 6	Benefits and Coverage, Hospice Care, or Facility Services (Non Hospital)
0655	Hospice Inpatient Respite Care	1, 2, 3, 4, 5, 6	Benefits and Coverage, Hospice Care, or Facility Services (Non Hospital)
0656	Hospice General Inpatient Care-Non Respite	1, 2, 3, 4, 5, 6	Benefits and Coverage, Hospice Care, or Facility Services (Non Hospital)
0657	Physician service	1, 2, 3, 4, 5, 6	Benefits and Coverage, Hospice Care, or Facility Services (Non Hospital)
0659	Other hospice	1, 2, 3, 4, 5, 6	Benefits and Coverage, Hospice Care, or Facility Services (Non Hospital)

FACILITY NON-COVERED CODES		
Revenue Code	**Description**	**Benefit Plan Reference/Reason**
0658	Hospice Room and Board; unless specified in Contract	All Other Exclusions. Health services and medical supplies that do not meet the definition of a Covered Health Service.

Verification of Compliance
Claims are subject to audit, prepayment and post payment, to validate compliance with the terms and conditions of this policy.

6.0 Documentation Requirements:

Hospice providers must establish and maintain a clinical record for every individual receiving care and services.

- The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval.
- The record must include all services, whether furnished directly or under arrangements made by the hospice.

- Medical records should contain enough clinical factors and descriptive notes to show the illness is terminal and progressing in a manner that a physician would reasonably have concluded that the beneficiary's life expectancy is six months or less.
- Hospice benefit periods are unlimited as long as the above remains true and documentation of disease progression is evident.
- Generally, a beneficiary will show decline from one certification period to the next; however, this may not be the case for some beneficiaries whose condition may not run the normal course of decline and remain temporarily unchanged. However, documentation in the medical record should still show that the beneficiary has a six month prognosis.
- Documentation notes from multiple disciplines involved in the care of the beneficiary should demonstrate a picture of the beneficiary's terminal progression. Avoid vague statement such as "slow decline" or "disease progressing" that do not clearly support the terminal progression requirements; the more objective the documentation, the better.
- When receiving a beneficiary as a transfer from another agency in the middle of a benefit period, obtain a copy of the signed certification for that benefit period from the transferring agency to complete that benefit period. Remember that the benefit period does not change due to a transfer.

When a beneficiary's level of care changes, the documentation should show when the change occurred and the reason for the change.

5.0 Terms & Definitions:

Continuous Home Care (CHC) – Care that is provided only during a period of crisis and is necessary to maintain an individual at home. If a patient's caregiver has been providing a skilled level of care for the patient and the caregiver is unable to continue providing care, this may precipitate a period of crisis because the skills of a nurse may be needed to replace the services that had been provided by the caregiver. However, regulations do not permit CHC to be provided in an inpatient facility (a hospice inpatient unit, a hospital, or SNF).

See http://www.cms.hhs.gov/manuals/downloads/bp102c09.pdf for additional information.

Hospice Benefit Period – The 1st two election periods are for 90 days. Starting with the third benefit period, each benefit period thereafter is for 60 days.

Hospice Care – Services available to patients with life-limiting illnesses who can no longer benefit from curative treatment and usually have a life expectancy of six months or less, as determined by a physician.

It is a team-oriented approach to expert medical care, pain management and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is extended to the patient's love ones, as well. At the center of hospice is the belief that each of us has the right to die pain-free and with dignity, and that our families will receive the necessary support to allow us to do so. Care is usually provided in the patient's home. Hospice services are available to patients of any age, religion, race, or illness.

Non-Skilled Services – Care that consists of training or assisting in personal hygiene and other activities of daily living that do not provide therapeutic treatment and can be safely and adequately provided by someone without technical skills of a health care provider (e.g., nurse).

Palliative Care – Refers to any care that alleviates symptoms, even if there is hope of a cure by other means. Palliative care focuses on the pain relief, symptoms, and emotional stress brought on by a life-threatening illness. The illness does not have to be terminal to qualify for palliative care. Treatment may be used to relieve side effects of a curative treatment, such as relieving nausea associated with chemotherapy, which may help to tolerate more aggressive or longer-term treatment.

Skilled Nursing Services – Care that consists of services that must be performed by a RN or LPN and meets the following criteria for skilled nursing services:

Terminally Ill – A medical prognosis that indicates that life expectancy is six months or less if the illness runs its normal course.

6.0 References, Citations & Resources:

1. Centers for Medicare and Medicaid. Medicare Benefit Policy Manual. Chapter 9. Coverage of Hospice Services Under Hospital Insurance. Revision 209. 05/08/15. Available at URL address. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf.
2. American Academy of Hospice and Palliative Medicine. National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care. © 2009, National Consensus Project for Quality Palliative Care. Available at URL address: http://www.nationalconsensusproject.org/Guideline.pdf.
3. World Health Organization 2015. Definition of Palliative Care. http://www.who.int/cancer/palliative/definition/en/.

7.0 Revision History:

Original Effective Date: 12/26/2018

Last Approval Date: 12/26/2018

Next Revision Date: 12/26/2019

Revision Date	Reason for Revision
12/18	PRP created.

8.0 Document Evaluation Panel:

Document Owner:	Mollie Callow, Sr. Plan Standards Coordinator
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